



Se	Section One (To be Completed by Patient)									
Naı				DOB:			gram nber:	Week	Date:	
		ı O. I	1 2 17 24			•				
List	Changes to Med	licines Since L	_ast Visit	Foo	od Progr				 Healthy Living 	
					o Slir	m & T	rim ew Yo		Other	
	scribe any devia program:	ations from	Exercis	e:	Type of Exercis			cise:		
				e: □ Y □ eek: :						
List	Calories Cons	umed per Da	ay:							
Sys	stems Review	(Check if a cu		•			ı	T		
	Chest Pain		Swo	ollen Ankles				Shortne	ess of Breath	
	Dry Mouth			☐ Hair Loss				Palpitat	ions	
	Nausea			Vomiting				Abdom	nal Pain	
	Diarrhea			Constipation				Abnormal Bleeding		
	Other (Describe	e)		gue				Blood S	Blood Sugars (if Diabetic)	
	ction Two (Fo	r Staff Use O		e completed b	v Medi	cal St]			
	/sical Exam									
H&P Weight Previous W			Veight	Today's Wei	Weight We		eight Change		Total Weight Loss	
Ter	np:	O2:	Pulse:	Resp):			BP:	/	
	nptom(s) Revie	wed: 🗆 F	Plan:	_						
		;	Staff Sign	ature:						
Die	titian/Exercise l	Physiologist	Review							

Weekly Food / Activity Journal

Date	Week#	North Ottawa Community Health System
		—— ••• Health System

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Morning Snack							
Lunch							
Afternoon Snack							
Dinner							
Evening Snack							
Total Calories =							
Water Intake ⊕ = 80z.	0000	0000	0000	0000	0000	0000	0000
Exercise Activity (minutes)							

Total Exercise/Activity

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